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Bulletin of
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PEDIATRICS AND PSYCHIATRY

BY KARL MENNINGER, M.D.

Last year the editors of the *Bulletin* announced a series of issues dealing with the inter-relationships of psychiatry with the other specialties of medicine. The experiences of medical officers in the Armed Forces, where patients can be impartially and objectively considered by many specialists working together in groups, has tended to alter both the concepts and the techniques of the practice of medicine. Most impressive is the fact that the illnesses of so many patients arise or develop on a non-organic basis, thus putting them into the general category of psychiatric problems. Most physicians are not psychiatrists and never will be; at the present time less than 2% of American doctors are psychiatrists. Yet the statistical records of hospitals, clinics, private physicians, casualty lists and the like all indicate that something between a third and a half of all patients are essentially psychiatric in nature. The obvious conclusion is that more physicians in other specialties must add some psychiatric understanding and some psychiatric techniques to their professional equipment. The fact that there are not, at the present time, adequate plans or facilities or even definite ideas for the inculcation of that amount of information and that degree of expertness in psychiatric matters required by the physician in other specialties is a pertinent problem worthy of the concentrated attention of the best thinkers in the profession.

Pediatrics is a specialty in which the necessity for more psychiatric orientation was recognized by the profession long before the present war and one which, like obstetrics and gynecology, has received relatively little impetus from the war experiences. Dr. Henry F. Helmholz, chief of the section on pediatrics of the Mayo Clinic, told the writer in a personal conference at Rochester a few months ago that the pediatrician had been forced to open his mind to psychiatric concepts and techniques.

"Concepts of feeding techniques have so altered," said Dr. Helmholz, "and progress in the prevention and treatment of children's diseases has been so great that the pediatrician has found his field of activity radically changed. He has come to realize that the physical diseases of childhood are often less of a problem for him than the regulation of the life habits

and mental health of the child. This, in turn, has obliged him to study the effect of parental attitudes and the origins of these attitudes. He has thus been inducted into psychiatry by the force of circumstances."

Psychiatrists, on the other hand, were rather similarly forced into a better acquaintance with pediatrics through a similar evolution. Psychiatry was originally concerned primarily with the mental disturbances of adults. To be sure, there were occasional children with convulsions or behavior disturbances which attracted attention but in the main these were neglected problems. It was not until the monumental discoveries and researches of Sigmund Freud that psychiatrists came face to face with the fact that the mental afflictions of adults are regularly referable to the emotional conflicts, pressures, stresses and traumatic experiences of childhood. Psychiatrists began the study of children through the telescope, as it were, by learning of the childhood sufferings in the course of historical or psychoanalytic investigations of adults. Gradually, however, they approached closer and closer to original sources and began to give more and more attention to disturbances in children which had previously been regarded as trivial, inconsequential, transient and negligible. Like the pediatricians they were forced, then, to be more concerned with the pathological attitudes and behavior of parents, the results of which were manifested first in childhood and later in the adulthood of those traumatized children.

Gradually, therefore, a specialty within the specialty has grown up, that of child psychiatry. It has often been said, and cannot be said too often, that a child is not merely a small adult; he is a very different creature with different possibilities, different living and thinking techniques, different types of reactions. Belatedly these have been studied by psychiatrists and are being studied more and more, greatly aided by the investigations of pediatricians, child psychologists, psychiatric social case workers, child analysts, students of nursery school and kindergarten behavior, teachers and others with whom reciprocal relationships of helpful cooperation are increasingly being established.

It was the original intention of the editors of the *Bulletin* to center the articles of this number about such psychosomatic problems of childhood as might be collected from our joint experiences. It was soon apparent, however, that in a sense this would have been an antiquated and relatively sterile procedure. There may be some psychological factors, for example, in an attack of measles but their importance is academic and theoretical rather than practical and the pediatrician needs no particular help in that direction. As Doctor Helmholz said, the pediatrician is increasingly occupied with problems of a very different nature—problems in which the psychiatrist ought indeed to be able to contribute some helpful ideas and

suggestions on the basis of his experience. The psychiatrist sees many "grown-up" children still suffering from and reacting to the mismanagements, misconceptions and misadvantages of the childhood period. The psychiatrist also sees some of these childhood reactions in *statu nascendi*, and their relationship to his adult cases is inescapably clear. Hence the psychiatrist has developed some tentative conclusions and procedures in regard to child management which have, at least, a certain logic. In addition, the psychiatrist has come to have recommendations in regard to the management of certain common problems, erroneously considered minor by many parents, which are often encountered in the practice of pediatrics and general medicine. It is of these experiences and conclusions that we speak in the articles to follow. They are contributed in the spirit of proffered cooperation with our pediatric colleagues, from whom we need reciprocal studies and interpretations. We feel that in this way, and in this way only, collaborative medical science progresses.

THE PEDIATRICIAN AND THE CHILD

By ROBERT L. WORTHINGTON, M.D.

Not long ago I talked with a pediatrician who told me that in his war-busy city he was seeing more than 100 children a day. He could take only the more urgent cases and was plainly troubled by the knowledge that he had to neglect some of the most important aspects of his work. He knew that mothers needed to talk to him and yet he had no time for this. He knew too that he should have time to consider the emotional as well as the physical needs of the child, but what could he do about it? He didn't even have time to read about such things and, like most doctors, had received little or no useful psychiatric education in medical school.

This man knew the importance of the psychological aspects of child care and most physicians who treat children are at least somewhat aware of it. Not only are they the close advisers of the mother during the child's formative years but they often deal directly with the child in ways that may affect his emotional development seriously. Knowing as he does that the emotional problems of adults have their roots in childhood, what can the pediatrician do to help in the formation of strong, healthy minds as well as bodies and how can he obtain this knowledge?

When I finished my medical training I felt I was prepared to manage infant feeding and most of the medical and minor surgical conditions of childhood. I gave what seemed adequate advice on many problems such as toilet training, bed wetting and thumbsucking. However, as time went on I found that the advice I gave was not always so adequate and I began to look for other answers, as I am sure most pediatricians do. Also, I gradually became concerned about the wisdom of certain medical and surgical procedures or the manner in which they were carried out. I felt more and more that the child's emotional life was not being considered enough, either because of lack of time or because of ignorance.

From my experience and from my reading I came to feel that I needed to know more about these things and this led to my entering the field of psychiatry. To a certain extent my experience is typical; for while most pediatricians do not become psychiatrists, they are all faced with psychiatric problems with which they must cope in some way. For this reason, I felt that a few observations drawn from nearly 11 years in both fields might be of interest and use to some readers.

Every doctor knows that from the moment the infant is born he is faced with the struggle for existence, with the necessity of making an increasing number of adjustments to his environment. Many physicians forget or do not seem to know that the child's capacity to do this is greatly affected

by a number of specific things: the amount of love and security he receives, his nursing experience, his toilet training, the attitudes of parents and siblings toward him, and many more. All of these matters are dealt with rather fully in the literature but I want to take up certain things that are not so often written about but which are also of great psychological importance.

In the infancy period there are several frequently performed physical procedures that may be traumatic to the child's psyche. Circumcision of newborn infants, often done by the obstetrician, is now practically routine in American practice. If circumcision is necessary it is probably best done in the first few days of life for psychological as well as surgical reasons. However, many of these circumcisions are not necessary, the prepuce being neither too long nor too tight, and many of them are carelessly and improperly performed. To decrease the sensitivity of the glans is not the unmixed blessing it is supposed to be. Many parents request circumcision because they wrongly believe that it will lessen the chance of prolonged bed wetting and masturbation. Circumcision at this early age probably does not cause a severe psychic trauma as it may do at a later time, which will be discussed further on.

The various immunizations of the infant probably do no psychological harm if they are done with careful consideration of the child's feelings, but often they are not. Many times infants develop a lasting fear of the doctor when severely frightened during this and other minor but sometimes painful procedures. To take the child from his mother, place him in a strange environment, and then give him a painful injection may be quite terrifying, especially in infants already insecure for one reason or another. The mother should hold the child and distract his attention, perhaps with a cookie or toy, while the injection is being given.

A physical examination may frighten some children and should not be done in an abrupt or brusque fashion. As many pediatricians know, allowing the child to play with the instruments, or to examine the doctor or nurse, or distracting him with toys or candy are often helpful. It is the way in which such simple things are handled that may either build a strong and fruitful relationship between the doctor and child or destroy it.

Many pediatricians try to make their offices as much like a home as possible, thus affording the child a greater feeling of security instead of letting him be frightened by strange surroundings and displays of instruments which he may imagine to be tools of torture. Furnishing reception rooms with childrens' furniture, books and toys, making examining and treatment rooms less severe in decoration, and keeping most instruments out of sight, are helpful in lessening the child's anxiety. Many physicians have found that they could examine or treat a fearful child after previous

failures when they appeared in their business suits instead of gowns. With badly frightened children it is better to give up a procedure until a later time, unless it is extremely urgent, and to spend the time in letting the child become acquainted with you and the office. In these days of seriously overworked pediatricians such ideas may sound impractical but the benefit to the child is well worth the additional effort.

In the examination of older children, that is, from the age of about 3 years, it is very important not to spend a long time examining any one part of the body, especially the genitals, because this is apt to arouse undue fear in the child. For the same reason the child and his condition should not be discussed in his presence unless only reassuring things can be said. Many children develop lifelong fears of heart disease and other afflictions, in part at least, because of a careless remark dropped by a physician. Pediatricians, like the parents, often underestimate the small child's ability to understand what is said in his hearing and it should be remembered, also, that the child may misinterpret innocent remarks if they are ambiguous. On the other hand a secretive attitude should be scrupulously avoided.

In older children there are a number of things that are apt to be severely and specifically traumatic to the personality development. Preeminent among these are certain surgical procedures. A tonsillectomy is not simply the removal of diseased glandular tissue involving a little risk and only temporary alarm and discomfort to the child. It is a procedure that may, if ruthlessly done, cripple his personality for life. Unfortunately, tonsillectomies are often deemed most necessary between the ages of four and six. It is during this age period that the child is going through a great deal of conflict over various biological impulses, especially excretory and sexual problems. Parents often threaten their children in many ways in order to stop bed wetting and masturbation, even to the point of threatening actual castration. Because of these conflicting impulses the child is already in a state of fear, feeling that he may be injured in some way, even castrated, though he may not betray this to a casual observer. When a tonsillectomy, or any other cutting, is performed during a period when a child is feeling so threatened, he may easily feel that the threat is going to be carried out if he is not given adequate psychological preparation. Many parents and even physicians tell children that their tonsils are being removed to stop bed wetting, which, like masturbation, is often based on a sexual conflict. Circumcision during this age period may be even more damaging to the psyche and when the two procedures are performed simultaneously the emotional shock may be exceedingly severe and last a lifetime. Since these same sexual conflicts are reawakened in adolescence, similar results may obtain, although they are usually greatly lessened by the increased

knowledge and ability to understand at that age. An appendectomy is also not without its specific psychic dangers. The study of a number of cases has revealed that this too may be regarded by the child as a castration threat or experience.

Perhaps some of the greatest psychic insults are various procedures, some of which have already been mentioned, that are intended to prevent or cure masturbation and bed wetting. These problems, certainly masturbation, are usually psychological and yet often a drastic surgical procedure is undertaken almost as if to actually carry out the castration threat, instead of trying to understand the psychological problem or sending the child to someone who can. One of the most shocking and irrational procedures is the removal of the clitoris, an important sex organ. Almost as terrible is circumcision of little girls and the passing of vaginal or urethral sounds. Some time ago at this Clinic we saw a young girl who had had a circumcision "to decrease her nervousness," indicating the doctor's basic misconception that masturbation causes nervousness, since for what other reason would he operate on this organ? The child did improve for a short period after the operation as is often the case, probably because of the great fear induced. However, it was not long before she became psychotic, or nearly so, engaging in various compulsive acts to the point of severe exhaustion, refusing to eat and resisting sleep in every possible way. She nearly succeeded in her apparent aim of destroying herself but patient and prolonged psychiatric care brought her to a stable emotional adjustment. Although there were many other factors of importance in the background of her illness it became clear during her treatment that the circumcision had indeed been of the greatest significance. Not only may extreme terror be aroused by such procedures but the child's attention is certain to be focused on these organs to an even greater degree, with a more severe conflict resulting.

Psychiatrists frequently see children who have become psychotic following such procedures, yet they are recommended time after time in our leading medical journals and textbooks. For example, less than a year ago in the Queries and Minor Notes Column of the *Jounal of the American Medical Association* the following was given as the treatment of bed wetting:

"Unless bed wetting is caused by some definite condition such as cord lesion, vesical neck obstruction with residual urine or from a stone in the bladder, the most dependable treatment is dilation of the urethra with sounds or bougies. As with adults, meatotomy should be done when the meatus is small . . . . this plan of treatment is employed both for boys and for girls. The dilations are administered once a week and are usually the only treatment needed. The bedwetting usually stops after from one to ten treatments . . . . But with gentleness, a few pennies and 'Pop-

eye or football talk' the treatments nearly always may be carried out satisfactorily."

Angry responses from many doctors, including a medical school professor and one of my colleagues, brought a reply that "Our Query and Minor Note Department is now fully informed on the fact that the proper approach to this subject is probably almost wholly through the psychological rather than the physical side."

Unfortunately it is not widely known that masturbation is a perfectly normal part of childhood development and that when it is ignored it ceases spontaneously. The age-old taboo against masturbation is so strong however that drastic things are done to prevent it. Threats and even actual injury do nothing toward decreasing this natural impulse and although the masturbation may be stopped the conflict thus aroused is almost certain to do severe and permanent damage to the child's personality.

Careful weighing of the surgical urgency against the possible psychic injury should be a regular consideration of every physician treating children. This is especially true in fearful and insecure children. Careful psychological preparation of the child by the parents and physician will do much to lessen the possible damage. The child should be told exactly what is going to be done and why the procedure is necessary. His questions should be answered fully and frankly. To deceive him is far more damaging than any knowledge of the actual facts could be.

When anesthetics are necessary the psychological preparation is just as important as the physical, and even more important is the way in which the anesthetic is given. Too often an ether mask is clapped over the child's face; he is told to breathe deeply and is pinioned to the table. His screams of fear and rage bring only a further clamping down of the mask and more ether. There is seldom an excuse for such treatment in these days of better anesthetics and basal anesthesia. No longer is it necessary for the child to go to surgery fully awake and to be frightened nearly to death by strange sights and sounds.

Short, acute illnesses seldom present much of a problem but the child's emotional life must be kept constantly in mind during the longer, chronic illnesses. In any illness the examination of the child should be undertaken with the thought in mind that he may be more fearful than he appears, that a chance word, gesture, or pause may excite new fears or may substantiate fears already present. This is particularly true of children who have been ill frequently and in those who have or have been led to believe by their parents or others that they have a disease of some vital organ.

When a child has to remain in bed for many weeks or months, we have a problem similar to that seen in many compensation cases and in the war

neuroses. "Secondary gain" from the illness may become so great that there is little incentive for the child to return to an active life and continue with his emotional growth. By "secondary gain" is meant all of the gratifications a person may derive from being ill. In compensation cases for instance, on getting well a person has to give up an assured income and return to his work, as well as having to give up many little personal attentions he received while ill. In the war neuroses it is also well known that if the condition goes without treatment for any length of time, the "secondary gain" becomes great and the neurosis may become fixed. The sick soldier is not only assured of permanent care by his government but he does not have to return to battle or assume the burdens of life if he remains ill. These results are to be distinguished from malingering, a conscious deception. In the child we have a similar problem with long illnesses. He is already confronted with the extremely difficult jobs of growing up and of taking responsibility, and if given too great a chance to sidestep these he will take advantage of it and will regress to a more infantile state, especially if he also feels that his illness may handicap him in life in some way. We have all seen the child who again begins to wet and soil himself after becoming physically ill, who becomes more and more demanding of attention, and who in numerous other ways more or less gives up the struggle for maturity. In long illness therefore it is extremely important not to overdo treatment and coddling attention, but the child should be expected in various ways to keep up his former level of achievement insofar as his illness will let him. Often school work can be continued; certain responsibilities can be assigned to him; occupational therapy can be started and in other ways he can be expected to perform more or less on his previous level. Naturally, if too much is expected even further emotional regression may occur, especially if the child does not get the gratification he has a right to expect for his continuing performance in spite of a handicap, the most important gratification being the approval and understanding of those about him. The child who is ill for a long time should have the same frank explanations of what the trouble is and what he must look forward to as are given before surgical procedures. An optimistic reassuring attitude on the part of the physician and parents is of the greatest importance. Just as with the adult however, platitudes bore the child and do not reassure him.

The child who has to have frequent medical treatments over a long period may also suffer from emotional damage. This is especially true of those who have such conditions as hay fever, asthma, syphilis, and other illness requiring numerous injections or manipulations. Not only may each treatment frighten the child but he sooner or later becomes convinced that

he is different from other children, a feeling that may lead to chronic neurotic invalidism. Knowing these things, the pediatrician may do much to forestall serious trouble by his explanations both to the child and to the mother. This is especially true in such conditions as asthma in which there is always a severe emotional problem already present. Here again the pediatrician must be ready to deal with the tendency to regress and see to it that he does nothing to reinforce it, although it is not generally so strong as in the child continuously confined to bed.

It is well known now that obesity is the result only of overeating but not so well known that the overeating is frequently due to an emotional problem, usually chronic frustration and unhappiness. Here the physician must look into the home situation. He must also remember that to put the child on a severely restricted diet is adding just one more frustration which will only increase the tendency to eat. Failures to cause weight loss are usually due to the child's inability to stand that frustration, with consequent indulgence in surreptitious eating. The diet should be as bulky and frequent as is consistent with a gradual loss in weight and every effort should be made to get at the root of the underlying emotional problem. The youngster hates his obesity because it sets him apart from others, but since he does not receive other sorts of gratification he continues to overeat.

Rare is the pediatrician who does not often feel that the parents, especially the mother because she deals more with the child, are his greatest problems. Over-solicitousness and over-protection on the part of the parents may do far more psychic harm than neglect. These attitudes are usually the result of deep seated problems in the mother, but the pediatrician, by explanation, direction, and reassurance, may do much to minimize the effect of these attitudes on the child. Often he can relieve an anxious mother by a frank discussion of the fact that she can and does have feelings other than those of love for her child at times, that the child is a great burden and responsibility that she naturally resents, and that her attempts to counteract her guilt over these feelings by over-indulgence, over-solicitousness, and over-protection may seriously harm the child. Of course, he must use the utmost tact in this and have a "feeling" for the right opportunity. Another aspect of the same problem is sometimes seen when parents attempt to force the physician to "do something" or to treat the child in a way that may be against his better medical judgment. He must be particularly wary in such cases if he is to protect the child from parental hostility and guilt.

The pediatrician has a far broader and more important job than just the physical care of the child. He is dealing every day with developing

personalities in ways that may affect them greatly. To take this fact into serious account will add, I know, to the burdens of the already overworked pediatrician. However, not only can he find this aspect of his work tremendously interesting, but the returns to children and parents will be extremely gratifying to them and to himself.

To return to the problem of the pediatrician to whom I referred in the first paragraph of this paper, the fact that he is troubled because he feels he is neglecting his patients in spite of all he is doing, indicates a steadily growing change of attitude among doctors about what is "essential" and "most important" in the treatment of children. With increased understanding of the personality development of the child, pediatrics will undoubtedly be recognized as one of the most important of all medical specialties, perhaps the most important.

MOTHERING, FEEDING AND TOILET TRAINING IN INFANTS

By ELISABETH R. GELEERD, M.D.

In the course of the development of pediatrics as a branch of medical science, principles of hygiene and dietetics have held a prominent position. New discoveries regarding nutrition, infection, growth, and the peculiar diseases of childhood led to a revision in many of the time-honored methods of child care. The customs of our great-grandmothers were found, in many instances, to have been contrary to the best interests of the child and contributory to tuberculosis, marasmus, rickets and other afflictions which kept the child mortality rate so high. This program brought the science of pediatrics into an eminent and honored position among the sister specialties in medicine.

In this concentration upon the physical health of the child, however, certain aspects of the problem were forgotten. Among the methods of child care used by our great-grandparents some were discarded which the further study of the child has shown to be essential. These relate particularly to the personal relationships between the baby and those who care for him.

It is an elementary principle of psychiatry that man does not live by bread alone and that infants need more than proper food, appropriate vitamins, sufficient sleep and occasional pats. When a child feels uncomfortable because he is hungry or wet, too hot or too cold or unwell, he can do little but cry. Crying is an indication that the baby is in need of attention. Yet one often encounters the attitude that one should not give in to a baby's crying because this might spoil him. Of course as a child grows older, he gradually learns that his wishes cannot always be gratified immediately; for the young infant, however, to be left helpless and uncomfortable is an intense frustration, sometimes more than he can bear. He easily may develop an attitude which will persist during his whole life that the world is a bad place, full of frustration and loneliness. Such a child grows into a dissatisfied adult, always feeling that whatever he gets is not good enough or not the right thing. He tends to be pessimistic and easily depressed. Infants who receive much attention, who are willingly picked up and sung to and rocked, are much more responsive than those children who receive only "perfect physical care"[2, 7]. Whenever the attending person has to stop caring for a child, the infant immediately reacts by refusing food, or by tearfulness and discontent. In time he will get used to a new person and if this person is a motherly individual the baby will not have suffered a lasting harm. If changes are made very often, however, the child is almost certain to react to them adversely[3, 4].

He may develop a variety of symptoms such as eating or sleeping disturbances, colic, abnormal bowel function or generalized apathy. Sometimes he refuses food to the point of endangering his life and has to be hospitalized. In such instances a regime of "mothering" is as important in restoring the baby to health as is the medical treatment[7].

Sometimes a mother, for conscious or unconscious reasons, may not be able to mother her child properly. Conscious reasons may include worries about finances, estrangement from her husband, illness or death in the family, etc. These worries may preoccupy her to such an extent that she will not be able to devote all her love to the child. Unconscious reasons are rooted in the mother's own personality. If she has not had a satisfactory adjustment emotionally to her own parents and siblings, she will not be able to accept her rôle of mother to its fullest extent. Although she consciously tries to love her child, he realizes her underlying attitude toward him. She may hold the child clumsily or may "over-mother" him, handling him excessively after his feeding or when he is sleepy; she may talk to him in too loud or too cross a voice, or let him cry too long. When the maladjustment in the mother is a superficial one, consultations with an understanding pediatrician or psychiatrist may relieve her enough to enable her to take care of her child adequately. In severe cases she may have to relinquish the personal care of the child to a more maternal individual[7]; it is advisable for her to receive psychiatric treatment before resuming the care of her child.

If the mother is maladjusted, the child himself will usually become a maladjusted individual. For example, a little boy of five was brought to us because he had eaten poorly since babyhood and in addition was disobedient, aggressive, and had developed many fears. He was the fourth child in the family and his conception was an accident. The other children were fairly well adjusted. His mother stated that although she had not welcomed this child as she had the others, "once he was there it was all right." She was not able to nurse him as she had the older children, and he was put on a formula right away. He refused the bottle when it was offered to him but his mother forced the feedings down according to a prescribed schedule, although it sometimes took her an hour to an hour and a half to make him take the bottle. She would not stop until he finished the last drop and did not pick him up because she believed this would spoil him. The same inflexible procedure was followed as he grew older; whenever he refused a certain dish at one meal, it was set before him at the next meal, and the next, and so on until he had finally eaten the unwanted food. This invariably caused scenes which usually ended with the child vomiting his food.

He became increasingly aggressive and stubborn. When he was three

years old he had nightmares in which he was chased by a witch who tried to choke him. The mother was convinced that she loved the child and, indeed, the superficial observer would not have been critical of her management of him. In interviews with the psychiatrist the mother showed clearly that she had rejected this child from the beginning, had always compared him unfavorably with the other children and, although superficially she was friendly and loving to him, in many subtle ways she had pushed him away when he needed her most. In subsequent interviews it also became evident to the psychiatrist that when the child was born, the mother was no longer in love with her husband and this was the basis of her attitude toward the child. The situation was relieved a great deal when, through psychotherapy, she realized the nature of her feeling toward the child.

FEEDING

Pediatricians recommend breast milk because of its nutritional value. Breast feeding, however, is also superior from an emotional point of view. When the child nurses he not only satisfies his hunger but also derives pleasure from sucking, a satisfaction which is related in a broad sense to sexual gratification and which later contributes to a normal sexual life[5]. Therefore it is of great importance to realize that disturbances in early feeding may initiate a train of difficulties leading from childhood "feeding problems," finger sucking and nail biting to abnormal eating patterns in adults and to even more serious neurotic maladjustment. Unfortunately many mothers have difficulty in feeding their children because of a reluctance to do so which is usually rooted in a maladjustment in the mother herself[7].

Children differ considerably in their needs from the moment they are born. Some children need more food and at more frequent intervals than others[1]. Therefore, the feeding schedule should be adapted to suit the needs of the individual baby because young infants should not be left unsatisfied when they are hungry, nor should they be awakened from sleep to be fed. Hunger apparently arouses severe anxiety in an infant, anxiety which must be biologically rooted since, of course, without food the baby would die. His crying is an indication of this anxiety and it is the function of the mother or nurse to alleviate his fear as quickly as is practicable because the young infant is unable to cope with such tensions. Some skeptics may say that this would mean that the mother would be running to the cradle all day long and would be feeding the baby every half hour. Actually this happens only if the mother is insecure in her relationship to the child, whether from lack of experience or because she is temperamentally unsuited to care for the child intelligently. In the majority of cases after

a short time of experimenting, the baby establishes his own routine, a routine which really fits his own particular needs. Of course this will mean that the mother must spend more time with the baby at first, especially after she comes home from the hospital, and that she will need support from the pediatrician[6]. This will be rewarded by the fact that the infant will be better adjusted. Some compulsive mothers, however, are addicted to rigid schedules and become uneasy if the child is on a flexible routine. The child usually reacts unfavorably to this uneasiness and in such instances the flexible schedule is contraindicated.

WEANING

Modern dietetics requires the gradual introduction of new foods with new ways of taking them; when prescribing them it should be borne in mind that in general, infants do not take easily to new things. Therefore they should always be given a long time to prepare themselves for a new method and it should never be initiated when they are going through an upset period, such as might be caused by a cold or other physical illness, a change of routine like traveling, or the temporary absence of the mother or nurse. If possible at least partial breast feeding should continue until the child is about nine months old. Weaning always will be felt by the child as a withdrawal of a great source of satisfaction and therefore it should never be done abruptly. Gradual reduction of the number of breast feedings in a day combined with a slow acquaintance with the new mode of feeding from bottle, cup, or spoon is essential. Breast feeding extended past the age of nine months prolongs the pleasure in sucking to the point where it may become difficult for the child to give it up later. This may establish a life-long preference for oral activities with attendant personality problems.

The pleasure in sucking is apparently so great that most infants make sucking movements even when they are not hungry or being fed. By the age of a few months the child begins to put almost any object—a corner of the bedclothes, toys, and invariably its own fingers—into its mouth and suck. The finger sucking in particular seems to excite in most mothers the fear that it will become a habit. Unfortunately mothers do not always consult the doctor about the fingersucking and will resort to all kinds of suppressive measures such as tying the child's hands or putting bitter substances on its fingers. This will usually break the habit. But since the need to suck remains just as strong some neurotic symptom may arise in place of the finger sucking. Infants usually spontaneously relinquish finger sucking as the scope of their interests widens. For a variable period of time they fall back to this first pleasure under particular circumstances—when they are tired and sleepy, or frustrated and unhappy.

Compulsive and habitual finger sucking or its prolongation except on occasion beyond the age of from one and a half to two years indicates that the child is emotionally insecure and that the mother-child relationship is disturbed.

Since the practise of tying a child's hands or body is rather widespread, it is worth remarking here that restriction of a child's bodily movements is detrimental to its emotional and perhaps even its physical development in the sense of neuro-muscular coordination. Children's garments should not fit too snugly nor should bedclothes be drawn too tightly. The spontaneous kicking and squirming of the happy infant indicate the pleasure it takes in free bodily movement. Prevention of this pleasure upsets the emotional equilibrium of the infant and if movements are restricted over a long period of time neurotic difficulties may result.

TOILET TRAINING

Another factor in the infant's life which may be of great influence on his later personality structure is the handling of the toilet training. Excretion, like eating, is not only of physiological significance but also plays a great rôle in the later personality make-up of the child. In the first months of life elimination is a simple reflex phenomenon occurring with fair regularity. Although physiological stimulation of the muco-cutaneous junctions is pleasurable to infants from the very beginning, it is only toward the end of the first year of life that pleasure in emptying the rectum rises to the point where it supplants the pleasure in sucking. The passing of urine and feces has always been pleasurable but interest in defecation and playing with the feces now rises to a peak[5]. Mothers often have a tendency to train their children quite early, especially when they have observed the regularity of the bowel function in the first months. To their great distress, this regularity breaks down at the period of life when the elimination becomes an important source of pleasure to the infant. Investigation of children and adults with an obsessional or compulsion neurosis has shown without exception that this mental illness has important roots in the conflict between the desire to derive pleasure from elimination and the mother's insistence on toilet training. In the case of the boy of five described above, constipation was very marked. His mother had begun his toilet training when he was two months old. Later on she insisted on his sitting on the toilet until he had a bowel movement. Although she sometimes kept him there for an hour or more, her commands were usually disobeyed by the child who would soil his clothing the moment she gave up in desperation. This mother was a meticulously clean woman for whom everything and everybody had to be spick and span. Her own rigidity and desire for

cleanliness, reinforced by her hostility toward the boy, made her insist that her child be clean at too early an age. The result was that he became constipated later on in life with a tendency to accidental soiling during moments of fear and distress. He also became very stubborn and his stubbornness can be explained as the overflow into other activities of his persistent desire to keep his feces in defiance of his mother's wishes.

Interest in bladder function in infancy is not as great as that in bowel function and hence is much less likely to be a source of conflict at this time.

Unless their methods fail, mothers generally do not discuss toilet training with the pediatrician. In many instances he will have to introduce this topic in order that the mother does not employ faulty techniques.

Toilet training should not be attempted until after the child has passed his first year of life, and preferably somewhat later. The best period for toilet training is when the child himself indicates in some way or another his awareness of and interest in excretion, and when he is able to talk and to understand so that his mother can explain in words what she wants him to do. She should praise him when he meets her request. Training should never be attempted in times of upheaval in the child's life and he should not be scolded for an occasional "accident" even after he has established cleanly habits. Mothers should be told never to become angry on such occasions but to treat them casually. It is only for the love of the mother that the child will give up this source of pleasure and become trained. When the child is 2 years old one may expect him to control his bowels and to remain dry in the daytime. A breakdown of good toilet habits in a child is very often a sign of unhappiness or illness and should lead to a careful investigation of its causes. The arrival of a new sibling is one of the most frequent. Frequently toilet training breaks down when the mother is in distress or is ill or has to be absent for some reason. The child indicates by his soiling or wetting that he needs his mother and that he feels more like a baby because he has lost his sense of security. Renewed soiling may often be the first indication of threatening illness. At such times, mothers are inclined to punish their children and to worry lest they remain soilers or wetters. They need a great deal of reassurance from the pediatrician in order to tolerate the child's symptom and to correct it by relieving his sense of insecurity.

A neurosis is as crippling as poliomyelitis, often more so. The pediatrician can play an important rôle in relieving this burden of mankind by guiding the mother in the handling of her child. If mother or child are seriously maladjusted a psychiatrist should be called in early. The younger the child the easier it is to make corrections.

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A few general basic rules for management of infants can be formulated.

1. Young infants need a certain amount of "mothering" just as much as they need vitamins and calcium.

2. One should never forget that the relationship between the mother or nurse and the child is fundamental in determining his later relationships to all human beings.

3. Self-control should be expected to develop only slowly, and one should try not to ask for a new measure of self-control unless the child is physically and psychologically capable of the new step.

4. All changes in management and particularly those which require greater maturity should be made gradually and in periods of comparative freedom from physical or emotional stress.

5. Each baby has his own peculiarities or individuality and taste which have to be studied carefully and intelligently so that the routines fit the baby and not the baby the routines.

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A COMMON TYPE OF ANOREXIA SEEN IN RUN-ABOUT CHILDREN

C. ANDERSON ALDRICH, M.D.*

One of the clearest instances in which a purely physical difficulty gives rise to psychic disturbances is seen in the anorexia state most commonly found in the run-about child. The relationship of psychic disturbances and anorexia has been emphasized over and over in the literature, both pediatric and psychiatric, but this one, specific type of poor appetite has not, in my opinion, received the attention it merits. I refer to that seen in children from eighteen months to three years of age, who have previously eaten well but have insidiously begun to refuse food over a period of many months. This paper is prompted by the need for proper understanding of its causes because this leads to easy and satisfactory treatment, whereas, with neglect, therapy may be extremely difficult and complicated.

When seen in the early stages, the mother's complaint and the history of these children are so stereotyped as to be amusing. The mother comes in saying, "My baby doesn't eat enough to keep a bird alive." On inquiry it develops that during the first year the baby had eaten well and that the lack of appetite had come on so gradually during the second year that no definite time of onset could be stated. Almost invariably the mother responded by insistently urging the child to eat and had either increased the ration of milk or resorted to rich milk feeding, or both. She usually says, "The child takes her milk all right, so I thought I would give her more of it so that she would be well nourished." The physical examination, as a rule, shows a normal, well-nourished child.

In a few instances, urging of meals by the parents results in severe anorexia and emotional crisis, but in the vast majority the situation does not become too tense because the children are evidently well nourished and not in a critical condition physically. Nevertheless, the situation is potentially serious from both the psychic and physical standpoints in that many such children grow up with an aversion for meals which deprives them of the basic satisfaction of eating and restricts their intake of the various nutritive elements found only in a broader selection of foodstuffs.

The underlying reason for this difficulty is well established but has received little attention in most of the literature on child nutrition, and even in that on anorexia. Since an infant increases in weight from 15 to 20 pounds (about 7 to 9 kg.) during his first year, and only 4 to 6 pounds, (about 2 to 3 kg.) during the second, his need for building stones for growth

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becomes much less during this latter period. Hence, the demand for food decreases so that at two years of age a child's caloric need is measurably less than at one year. This is quite naturally reflected in the infant's appetite, which shows a marked falling off.

The mother, accustomed to spooning large bowls of food into her baby, becomes alarmed at his refusal and, because she has been well indoctrinated into the value of good nutrition, she redoubles her feeding efforts. This line of attack, as we all know, is met by more determined opposition from any baby who respects his own abilities. Under these conditions, the mother's attempt to increase milk in the feedings is understandable, as it is incidental to her failure to feed solid and semisolid foods in the amount she desires. Milk, being more or less a "path of least resistance" is allowed in larger amounts and the fat content is often increased.

Few people seem to realize that the run-about child who drinks a quart or more of a high-butter-fat milk is taking in that form alone more than half of his total caloric requirements. It is not surprising that he has little desire to eat vegetables, fruits, cereals, meat and potatoes. As a matter of fact, one slice of well buttered bread at each meal, plus the milk, would supply almost all of his caloric needs.

While milk is an excellent food, it is not a comprehensive one for a child past the first few months of life and it surely should not be given in amounts sufficient to block out all other sources of good nutrition. The pathogenesis of this common type of anorexia then can be summarized as follows: (1) the physiologic loss of appetite due to the decreased demands of growth; (2) undue urging by mothers unaware of this tendency; (3) increased resistance to food due to the parental insistence, and (4) substitution of more milk as the path of least resistance.

Early recognition of this series of events immediately suggests methods of treatment which are successful rather quickly.

This condition is easy to *prevent*, if mothers are forewarned about the decreasing appetite of the second year. If they understand why this happens, few will make the mistake of forcing food at this time. Those in charge of well baby clinics should make this information available to mothers in the first half of the second year in order to prevent the commonest type of feeding problem seen in run-about children.

In the well-established case it is necessary to institute two methods of treatment; first, the immediate abolishment of coercion and, second, drastic reduction in the milk intake. As a rule it is a relatively easy matter to prevail upon mothers to stop forcing food in this particular situation because the reason for the poor appetite is so obvious and because the children are, in most cases, so definitely well nourished.

Reduction in the caloric intake from milk may be accomplished either

by reducing the intake to less than one pint daily or by removing the cream and restricting the butter in foods.

It is obvious that treatment of this condition, when seen in the relatively early stage, requires little if any of psychiatric technics. However, in many such patients the diagnosis is delayed, either because the condition is unrecognized or because professional help is not sought so that, in these children, a long train of more serious developments may occur. One group of these sequelae is physical, where, due to reduced and restricted diets, the child develops a true malnutrition, either quantitative or qualitative. Another group of symptoms is psychologic in its nature and results from the personality changes which follow constant clashes over meals between child and parent.

These difficulties are important because they interfere with a child's basic security in two well-recognized ways. First, a mother who constantly indulges in censorious or compulsive talk at meals three times a day necessarily makes her child feel inferior and insecure in her acceptance of him; second, in denying her child free use of his appetite abilities, she takes away from him an important function which is meant to be inherently controlled. Probably one of a child's most fundamental sources of confidence results from his ability to control basic body functions, eating, sleeping and eliminating, without undue outside interference. Denial of any one of these abilities to a child is psychologically crippling; it makes him insecure and this, in turn, may result in many symptoms unrelated to eating.

A child, then, who has been suffering from this type of anorexia improperly handled or untreated over a period of years may be presented to the psychiatrist as having an advanced neurosis because the original, simple lesion is thoroughly hidden by the prominent symptoms of insecurity. In such instances, treatment will have to be aimed at the psychic as well as at the physical factors.

SUMMARY

A common type of anorexia based on a normal growth tendency is described. Its early treatment which is quite simple is outlined. It is mainly directed toward the physical or dietary causes. Treatment of protracted cases in which psychologic sequelae have occurred requires expert psychiatric handling plus a knowledge of the original lesion.

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BEHAVIOR PROBLEMS AND HABIT DISTURBANCES IN PRE-ADOLESCENT CHILDREN: THEIR MEANING AND MANAGEMENT

By ROBERT P. KNIGHT, M.D.

The greatest possible opportunity for practical mental hygiene lies in the rearing of children. How frequently this opportunity is muffed through parental ignorance is attested by the high incidence of emotional maladjustment, delinquency and mental illness in our youth, both in the armed forces and in civilian life. Fathers who use a high grade of intelligence and judgment in their occupations display an amazing lack of awareness of and incapability for handling the human psychological problems of their children. Mothers who are excellent home managers become baffled by the behavior reactions of their sons and daughters. And teachers, those auxiliary parents to whom we entrust our children for supplemental rearing, except for comparatively few who are alive to their responsibilities for learning and using what has been discovered about human psychology, seem to feel that their duties are adequately discharged in plowing through the daily assignments with as little personal annoyance from their pupils as they can arrange. Why is it that the practical application in child rearing of the now well-known facts of human psychology lags so far behind the application of all other scientific discoveries? Why do we handle human raw material with but a fraction of the intelligence and skill that we habitually employ in developing and handling machines, natural resources, and chemical or electrical forces? And, for that matter, why do we appropriate millions of dollars for the development of non-human materials and forces and skimp like a miser when it comes to spending money for the research study, development, and care of our human resources?

I have raised more questions than I can answer, but before discussing the meaning and management of specific problems in child rearing I would like to dispose of some of the prevalent misconceptions that stand in the way of utilization of our scientific knowledge about human beings. I wish to call attention to four outstanding misconceptions or practices which lead well-meaning parents and teachers into serious errors with the children they are trying to make into good citizens.

1. The belief that everybody knows enough about human nature and "psychology" to rear children, advise others on all human difficulties, and "handle people" if he just uses "common sense." Complacent in this comfortable conviction, people can scoff at psychiatry and psychology and dispense free advice to their friends in dynamite-laden emotional problems whereas they would not presume to offer advice on how

to deal with a compound fracture of the thigh or a high fever. "Common sense" is too often the sum total of that individual's own particular experiences and attitudes, narrow vision, collected clichés and misinformation.*

2. The tendency to react to one's own rearing either by copying exactly the disciplinary methods used by one's own parents or else by swinging to the opposite extreme. Imitation of parents' methods is usually done by those individuals who grew up fairly submissively or who returned to the fold after some sowing of wild oats. Fairly well satisfied with themselves as products of their parents' rearing they apply methods used with them to their children, whether they fit or not, and are nonplussed if they seem not to work. Those individuals who hold unresolved resentments against their parents are likely to try to avoid their parents' mistakes by using indulgence where their parents were strict, liberality where their parents were niggardly, and so on. Neither slavish imitation nor equally slavish avoidance of the old folks' tactics is a sound basis for bringing up a new generation.

3. The belief that children should be as little nuisance as possible. According to this theory, the child is, or at least should be, a "little adult" as quickly as one can intimidate him into being docile, clean, quiet, and obedient. Mothers of this school make of toilet training a kind of war of attrition against the child and emerge triumphant with a clean, dry baby at eight months, oblivious to the emotional time-bombs they have planted in his soul. The home is to be a place of order and quiet, with no messes and no bedlam of children's noises. Many teachers have the same idea of managing children. Reduction to a minimum of the annoyance of having the "brats" around can be nicely rationalized into instilling good habits early. Such evidences of barbarism and original sin as "talking back," disregard for property rights and general "orneriness" are to be stamped out ruthlessly by blitzkrieg methods before they get a beachhead established in the child's personality.

4. The attempt to follow the precepts supposedly emanating from the "new psychology." In some ways this is perhaps the most tragic misconception in child rearing, for parents who make this attempt are well-meaning seekers of the truth. That they falter and become bewildered and inconsistent is sometimes due to their multiple shifting of the course of discipline after hearing or reading each new idea. Basic principles are missing, and polar opposite methods are simultaneously employed. Having heard that the great danger in bringing up children is causing inhibitions to develop in them which will cripple their lives, they use no discipline, no punishment, no restraint and rear playboys, delinquents, and psychopaths.

*For a powerful indictment of this kind of "common sense" see pp. 9–14 of *The Human Mind* by Dr. Karl Menninger.

Having heard that parents should be pals to their children, they abdicate their authority as grownups and parents, sacrificing their dignity and their children's respect, in a strenuous but futile attempt to be contemporaries of their children. Having heard that "love" is the most important thing to give the child they give a hovering, over-protective, managerial devotion that is both smothering and devitalizing.

Actually there is no body of theory and fact known as the "new psychology." There is, however, a growing science of human dynamic psychology, contributed to by many different "schools" of psychology and psychiatry, some of the ideas of which have been distorted into false theories of child rearing. The sound principles of dynamic psychology require skillful interpretation and translation into practical advice for parents, and the psychiatrists have perhaps been less adept and effective in this task than some of the lay writers of newspaper columns and books for parents. In the concluding section of this paper I shall attempt to describe a framework of guiding principles for parents and educators, rather than a list of rules covering the innumerable separate issues encountered in child rearing. But first I should like to discuss what kinds of behavior are to be regarded as more or less normal and inevitable in preadolescent children and what kinds are to be considered more serious problems, with suggestions for the management of both.

"NORMAL" BEHAVIOR

Children are not "little adults" but a special species of human beings in various stages of evolution from dependence, irresponsibility and bewilderment to some degree of maturity. Adults who have forgotten their own childhood irresponsibility, noisiness, dirtiness, curiosity, dishonesty and resentments toward grownups, or who were processed by strict discipline into "little adults," have a hard time tolerating these normal manifestations in children. A benign tolerance combined with a continuous educative process will keep all of these manifestations within bounds, whereas drastic measures usually increase the difficulty to an enormous degree. Two examples will illustrate this point.

I. A mother gave her six-year-old son five pennies to place in the collection plate at Sunday School. Having no allowance and no other source of money to handle, the boy regarded the obedient deposit of the valuable coins in a plate already containing a lot of money as a great waste. He pretended to put the pennies in the plate but kept them securely palmed. After Sunday School he bought five cents' worth of candy and ate it before going home. It so happened, however, that the Sunday School teacher observed this fall from grace and phoned the mother the sordid story. When the boy arrived home, his mother, already armed with

the facts, questioned him casually as to whether or not he had contributed the money as instructed. After leading the boy into a number of incriminating falsehoods she suddenly informed him she knew he was lying and that furthermore he was a thief—the worst kind of thief, for he had stolen money meant for God's work. She then wept demonstratively over this apparent evidence of early criminality in her son, was unable to eat the Sunday dinner, and retired to her room for the rest of the day. The boy was bewildered and disturbed, but the main lesson he learned was that one has to be more cautious and clever to avoid getting caught. Fifteen years later, after many similar drastic measures, he was forging his father's name to checks, running up large bills on charge accounts which his father had to pay, and lying smoothly while looking the questioner straight in the eye. Had this mother evaluated the childhood incident properly she would have told him at once he had been observed instead of leading him into a lie, would have tolerantly instructed him in the value of honesty and avoidance of trickery, and furthermore would have arranged for a weekly allowance of five or ten cents which he could spend in any way he pleased. He could lose it, throw it away, spend it all at once or save it; it would have been his to experiment with, and she would have met the child's *need* instead of seeing crime in *statu nascendi*. Had he been permitted to make his mistakes with pennies and to learn by trial and error and by parental suggestion, the issue in terms of hundreds of dollars and serious criminality very likely would never have arisen.

II. A father, himself in analytic treatment for recurrent depressions, related that his seven-year-old son had proudly shown him an outline drawing of a horse which was far too well done, claiming it as his own sketch. The boy's two-years-older sister actually had considerable talent in drawing and had earned much praise from the parents for her sketches, thus arousing considerable envy in the brother. Oblivious to the child's emotional *need*, the father viewed the horse with a skeptical eye and asked the boy again if he had really drawn it "free hand" or had traced it. The boy insisted stoutly that he had drawn it. The father then did some detective work until he found the original horse in a magazine and saw that the child's drawing was a tracing. He confronted his son with the evidence, told him he had lied to his father, that lying was very, very wrong and he must be punished. A sound spanking followed. Truth had triumphed, but what of the far more important question of the emotional significance of this incident to the child? Truth can conquer in more subtle ways, too. The father could have recognized that the boy wanted to please him and to be praised by him too, like the sister, and he could have praised him for his excellent tracing. There was no need to raise the issue of *lying* directly. He could then have shown him how to do other kinds of tracing—on the

windowpane, with carbon paper, with tissue paper—and have told him that that was a good way to learn to draw. After some practice the boy might have been encouraged to try to draw something without tracing it. Also, other achievements of the boy could have been praised so that he would no longer feel a need to extract praise by deception (if, indeed, the boy had actually intended to deceive).

Most children under seven or eight are unable at times to distinguish truth from fantasy, and often are afraid to tell the truth when questioned about some dereliction for fear of punishment. It is beside the point to corner them on the moral issue of lying. Persistent reality correction, recognizing and meeting their emotional needs, and making the truth easy to tell are much more effective educative methods.

The same attitude should prevail toward the almost inevitable incidents of "stealing" by children—bringing a playmate's toy home, picking up something desirable at the store, taking money from mother's purse. The toy must be returned, the merchandise taken back or paid for out of the child's allowance money, and patient, continuous instruction in property rights, ownership, and money transactions must be given, but without expressions of horror, the warnings of police and jail, and talk about thieves. At the same time one tries to meet the particular need of the child, indicated by the dereliction, in such a way as to make the dishonest method unnecessary. A regular weekly allowance, increasing gradually and never withheld as punishment, with encouragement to work for pay for the parents and neighbors is an essential educative method.

"Talking back" is one childhood manifestation that many parents feel must be ruthlessly suppressed. It is true that impudence cannot be tolerated and that parental authority cannot be permitted to be challenged defiantly. However, many parents and teachers will not even allow a child to say a word in his own defense, or attempt to explain. Yet under other circumstances than when *they* are offended they urge the child to stand up for himself. The importance of permitting a child to state his case as he sees and feels it, to assert his rights—even toward his parents or teachers—is too great to confuse it with any such false issue as "no talking back." Talking back when fairly permitted, with the parent giving the reasons for his decision, and firmly adhering to it unless he discovers from what the child says that the decision is incorrect and should be modified, does not lead to impudence and defiance. And talking back, in the sense here defined, avoids the intolerable frustration and dammed up resentment which result when the child is both forbidden something and prohibited from saying anything about his feelings.

Every healthy child will feel resentful and aggressive toward his parents at times. He may say it out loud: "I wish you be dead"; "I'm going to

run away"; "I hate you"; "I'd like to cut your head off." To become horrified, whip him severely, and send him to his room will only drive this external expression of his resentment inside him to be elaborated in bloody fantasies with consequent fears and guilt feelings. It is much better to be undisturbed and make some such reply as: "I'm sorry you feel that way just because I can't let you stay up longer (or whatever). Mother loves you and knows you won't feel that way very long. Come on now, we have to go to bed." Such a response lets the child know that he cannot *really* hurt his parent with words or thoughts, a very important psychological truth for a child to learn, whereas the parent's violent reaction to the expressed resentment only makes the aggressive wishes more awesome and real.

Frankly sexual behavior in young children is another manifestation of frequent normal occurrence, but one which often horrifies parents. Childhood masturbation, mutual exposures and examinations of playmates of both sexes, even abortive attempts at intercourse, are only part of the child's curiosity and experimentation in the learning process, and are not evidences of depravity. Far more psychological harm is done by the parents' manifest shock and horror than by the experience itself. Wiser methods include appropriate explanations about sex differences and sex functions and skillful diversion of play into other channels. Children have a hard time reconciling their parents' extreme disapproval of everything sexual with the later discovery that the parents themselves do sexual things with each other and have been doing so all along.

The rest of the usual childhood behavior which is normal, even though it is distressing to parents—noisiness, vulgarity, dirtiness, disregard for good manners and social niceties, irresponsibility, and so on—are best tolerated more or less indulgently while the slow civilizing, educative campaign of child rearing is being consistently carried on.

PROBLEM BEHAVIOR

In the last analysis, problem behavior in children represents the result of mishandling by parents of behavior that originally was within normal limits, or the reaction of children to certain traumatic attitudes or conditions in the home, or the effect of certain unfortunate experiences outside the home—or some combination of these. Child behavior becomes a problem when it goes to an extreme, when it persists and develops instead of being a transient manifestation, and when parental ineffectiveness becomes obvious to the child—either because the parents frankly admit and demonstrate their incapacity for discipline or because their most drastic methods have failed. Problem behavior may indicate that character development is proceeding in an abnormal direction or it may mean that some kind of

neurotic or psychotic illness is developing. Competent professional advice is essential, and treatment of the child, in addition to revised methods according to the advice given, may be necessary.

It is impossible, within the limits of this article, to list and discuss comprehensively the great range of possible problem behavior manifestations,* their detailed psychological mechanisms and the best methods for handling every variation. Each case has its individual mechanisms and the methods to be advised must depend on the pertinent factors in that child's experience and home situation and on the degree and persistence of the trouble. However, I shall give a fairly comprehensive list of the most common disturbances with some comments about each one.

1. Temper tantrums are usually more or less calculated, intentional emotional outbursts by a child to gain a point against the parents through a method found to be effective in the past. Crying, screaming, kicking, writhing on the floor—whatever the form they take—has been successful before in influencing the parents to relent in some adverse decision. The obvious answer to this would be for parents never, from the beginning, to be influenced into changing a decision by such behavior. Instead they should meet the behavior firmly, adhering inexorably to the decision made, banishing the child to his own room for cooling off, or, if that doesn't work, administering a spanking then and there. The essential point is to rob the tantrum of its effectiveness and to make it unpleasant. Spanking is by no means a method of discipline condemned by psychiatrists. Its occasional appropriate use may be an essential part of firm, consistent discipline. However, it should not be the first resort, it should be done privately, it should not be a "beating," it should not be done by the father only as his first duty on coming home in the evening and getting the mother's report of the children's behavior for the day, and it should not be done in anger. If the children are confident that they are secure and loved and if they from early infancy have learned to recognize with respect the note of authority in the parents' admonitions and prohibitions, spankings will be necessary very rarely. Other kinds of corporal punishment such as blows of the fists, humiliating face slapping, beating with sticks, boards, whips, and so on, are condemned as disciplinary methods.

There is a different type of tantrum, described in a recent paper by Dr. Elisabeth Geleerd,† which seems to be paranoid in character and requires soothing, mothering and security, but this differentiation must be made after careful study by a child psychiatrist.

* For a comprehensive discussion see pp. 139–176 of *Common Neuroses of Children and Adults* by Dr. O. Spurgeon English and Dr. Gerald H. J. Pearson.

† *Some Observations on Temper Tantrums in Children.* To be published in the American Journal of Orthopsychiatry.

2. Childish tyranny refers to demanding behavior, insolence, and defiance in a child who is also usually over-dependent. This state of affairs can come about only if the child has gotten the upper hand over a mother who has been too indulgent and spoiling, too solicitous, and lacking in consistent firmness. Consistently refusing to accede to the child's importunate demands, insisting that the child do the things he can do for himself, would have prevented such behavior from developing in most instances. A change to consistent discipline while the child is still small will usually bring such tyranny to an end, but if a child reaches the late teens under such a weak parental regime all the king's horses and psychiatrists may not be able to effect a change.

3. Timidity and fearfulness, with associated anxiety spells, nightmares, fears of being away from home or away from mother, may be due to too much parental strictness, usually combined with doing too many things for the child that he should be learning to do for himself—feeding, dressing, bathing, finding his things. His decisions are made for him and he has but to appear helpless to get his mother to do things for him. Occasionally temper tantrums and childish tyranny may be combined with the timidity. To maneuver him out of such a childhood neurosis, the fears and resentments must be uncovered and dealt with by a child psychiatrist and at the same time the mother's attitude must be changed by appropriate re-education and advice.

4. Apathy, indifference, isolation, inattention and day dreaming are rather ominous signs at any age, but especially in childhood are they alarming because a healthy child is eager, energetic, curious and alert. Such symptoms represent a kind of withdrawal from the real world of childhood into a fantasy world and foreshadow a developing mental illness unless skillful therapy can draw the child out into normal interests again.

5. Over-obedience, compulsive neatness and perfectionism represent a set of reaction formations to rebellious defiance, and while such attitudes may please the undiscriminating parent, trouble usually lies ahead. Such ideals are very difficult to sustain and failure or frustration is almost inevitable. A child with such trends will tolerate failure very poorly, with consequent depression, hopelessness and self-destructive tendencies. The parents can help by not pushing the child further in this direction through over-ambitious expectations and plans, but psychiatric help may be needed to relax these "too good" tendencies.

6. Cruelty, bullying and over-aggressiveness may develop out of resentment for the imagined favoring by the parents of a younger sibling or as a result of the child's feeling he is treated in a cruel, rejecting manner by his parents. Aggressive behavior of this kind usually covers many fears and feelings of insecurity. More affectionate management of such a child and taking into

account his possible distress at seeing his younger sibling receive care and attention may be sufficient to alter his aggressive attitude. If not, psychiatric consultation should be sought.

7. Running away from home or school, where it is not due to real mistreatment justifying such an attempt to escape, may represent a desperate attempt to be independent, to deny the strong need for affection and support from adults. Such behavior is more frequent in adolescence or late pre-adolescence and is usually quite abortive in younger children, who rather quickly and gladly return home after feeling impelled to carry out a threat to run away.

8. Frequent accidents and injuries, such as broken bones, falls with resulting cuts and bruises, gashes from sharp objects may indicate a considerable degree of unconscious guilt with need for self-destructive punishment. Any venturesome child may have occasional accidental injuries, and this heading refers only to those repeated injuries which begin to make one suspect that some purposive tendency exists in the direction of self-injury. A close inspection of the relationship between the child and both parents, as well as between the siblings, or among the child's playmates, may disclose the source of the guilt feelings which are being paid off in this way. Usually this is a transient phase in a child.

9. Sleepwalking may be combined with falls and injuries or may occur alone. Many children will sleep-walk during an acute febrile illness, being somewhat delirious at the same time, and transient or occasional sleepwalking, in which the child seems to have difficulty being awakened and appears to be acting out some bad dream may almost be within normal limits. Sleepwalking which persists well into the teens requires psychological investigation to discover and make conscious the impulses and desires being acted out in sleep. Hypnoanalysis is often effective in such cases.

10. Lying usually develops out of childhood fantasies which are either ignored by the parents or over-reacted to by them with violent attempts to establish truthfulness. Sometimes a child finds that skillful lying gets him into less trouble than telling the truth does. Persistent lying, especially needless lying, up to and past the age of ten is usually accompanied by other types of problem behavior pointing to developing delinquency or mental illness. Treatment in a psychiatric school may be indicated if advice obtained from a psychiatrist and followed consistently by the parents is ineffectual.

11. Stealing may result from external influence of companions but this source is probably over-emphasized, for such tendencies must be already present for the external "bad influence" to have any effect. Failure to start early teaching a child how to handle money by giving him an allow-

ance, paying him for special work done, and letting him buy what he wants with what he has, is undoubtedly related to stealing tendencies. Children of four or five should be getting a regular allowance and taking care of their own small funds. If, instead, a parent makes a child ask for money each time he wants something, continuing this into adolescence, there develops a great temptation to steal, first from the parents and later from other people. Of course, factors in the home ideology, such as the attitudes of the parents about honesty, the family economic status, and group influences in the neighborhood play a part in many cases. A careful survey of all such factors in a psychiatric study is indicated.

12. Persistent thumb or finger sucking beyond infancy indicates that the child has come to depend on this device for soothing his anxiety. He may not be able to go to sleep without a finger in his mouth or may automatically put his thumb in when growing sleepy, or on becoming disturbed while awake. Thumb sucking in infants indicates that the child is not getting enough satisfaction of sucking in nursing at the bottle or breast. No direct steps should be taken in infancy beyond increasing the time at the breast or bottle and giving the child more affection. If this does not suffice, pulling his finger out of his mouth after he is asleep, then waiting to pull it out again if he puts it back and continuing this consistently may stop the habit. The main concern later is with possible resulting malocclusion and deformation of the palate.* If the cooperation of the child can be enlisted in trying to stop, no punishment being given for failure, but praise being freely given for success, the difficulty can rather quickly be brought under control. Such measures as bitter substances on the favorite finger, gloves, and metal devices over the thumb or at the elbow to prevent bending it are last-ditch measures after everything else has failed, including advice obtained from a child psychiatrist.†

13. Nail biting also represents a way of reducing anxiety and may evolve out of earlier thumb sucking. Similar measures to those described in #12 should be tried. In girls the cosmetic appeal is often effective.

14. Persistent enuresis or soiling after the age of three indicates a psychosexual conflict of considerable degree. Any child may have some occasional relapse in wetting or soiling, especially in reaction to some disturbing event, such as the birth of a new baby, a death in the family, separation of the parents, being left with a nurse while the parents take a trip, and so on. But persistent wetting or soiling in the absence of such special traumatic events requires careful scrutiny of the whole setting and all the child's relationships by a competent child expert. Punishment or shaming by the parents should never be done, but control of fluid intake

* Authorities disagree about the seriousness of this possibility.

† Many psychiatrists would say "never."

after the evening meal, getting the child up again when the parents retire, and praise for dry nights may be sufficient.

15. Excessive or open masturbation refers to almost constant handling of the genitals, with erections in boys, sometimes done in the presence of others while seemingly oblivious to their presence. One would almost certainly find other disturbances also in such a child—perhaps apathy, distractibility and states of preoccupation. Punishment and shaming are again contraindicated, and the underlying conflict should be sought with the help of a child psychiatrist.

16. Fire setting in children can develop into a serious matter and requires prompt management. Invariably other behavior disturbances and psychosexual conflicts will be found to be present. Psychiatric advice should be sought and a complete psychological examination done, followed by the type of treatment and management indicated.

17. Persistent transvestism refers to frequent or habitual wearing of girls' clothes by boys or vice versa. The latter has far more social acceptance than the former so that transvestism in boys represents a greater deviation from normal behavior. The wish to be a girl—identification with mother or sister—underlies such behavior, and feminine mannerisms and interests may be associated. Using of fingernail or toenail polish, or posing and dancing before a mirror clad in girls' dresses or undergarments may be carried on secretly, and other perverse tendencies, such as fetishism, may be present. Parents interested in the normal development of their child will not let this go, believing complacently that the child will outgrow it, for later on it will be more firmly fixed and the whole personality development goes along in key with the transvestism. Psychiatric help is essential here.

CONCLUSION

Child rearing is a very specialized and complicated occupation, proficiency in which is not conferred on a couple when they get married. Parents who are themselves immature and unstable will inevitably have problem behavior in their children, while parents who may be mature in most ways may have, for psychological reasons arising out of their own experience, unfortunate attitudes of antagonism and intolerance toward the "annoyances" of normal child behavior, or misconceptions and distorted theories about how to rear children.

Education for parenthood should be incorporated in the curriculum of secondary schools and colleges. Courses in mental hygiene and dynamic psychology should include sound psychological principles of child rearing so that this enormously important factor in the future mental health of the new generation is not left to chance, ignorance and the parents' own

"common sense." Similar courses for prospective teachers outrank in importance the instruction in teaching subject matter.

Children, in the vast majority of instances, will develop normally if the following conditions are present:

1. Consistent, real affection from both parents so that the child feels wanted and secure. Such real affection will mean that the parents also want the child to develop independence, and have individuality and rights.

2. Consistent, firm, united discipline from both parents, carried out with reference to the child's needs rather than to the parents' comfort. All children need such parental disciplinary restraint to protect them from feeling anxious and helpless in relation to their own instinctual drives.

3. Sufficient understanding of, tolerance of, and ability to identify oneself with children to permit sensing what the child needs and what he is trying to accomplish by his various struggles and techniques. A few persons seem to develop this naturally as a product of their own experience and psychological-mindedness; others need to read and study intensively in order to be adequate to the parental responsibility.

4. Willingness on the part of the parents to seek counsel and help from competent child psychiatrists when problems arise which are beyond the parents' understanding.

THE PEDIATRICIAN AND THE EVALUATION OF EMOTIONAL MALADJUSTMENTS IN CHILDREN

By EUNICE M. LEITCH, M.D.

There are few who would question the statement that the early recognition and appropriate treatment of emotional maladjustments in children is of far-reaching importance. It is spoken for by gains accruing to the child, to his immediate environment, to the physician and to society at large. From the point of view of the child, the earlier the treatment, the less prolonged is his unhappiness, the better his chances for alleviation and recovery, and the greater the likelihood of his developing into an efficiently functioning adult. Not infrequently the environment suffers because of the child's illness. Always the child suffers, especially if punished or rejected in some way because of his symptoms.

The childhood years are formative years and sometimes in later life the most strenuous therapeutic endeavors fail to undo the ravages of a fundamentally thwarted, deprived early existence. From the point of view of the physician, early and appropriate treatment of maladjusted children means an ultimate saving in expenditure of time and energy, while society at large reaps its benefits in less mental illness in the population with a consequent reduction in unhappy ambulatory misfits and in admissions to mental hospitals and to jails.

The most pressing problem of child psychiatry today is that the number of child psychiatrists is grossly inadequate. But, need it be thus? Why should there not be established by pediatricians and child psychiatrists child health centers where the child's emotional and physical problems would each be given the same prompt attention? And who is in a better position to appraise a child's emotional adjustment at a particular time than his pediatrician? He is the one who by virtue of his repeated contacts with the child and his parents has a continuous anamnesis which is always difficult for the psychiatrist to secure. He and not the psychiatrist is usually consulted by the parents when the child seems indisposed in any way. His counsel is more acceptable to them than the counsel of any other person. And often, busy as he is attending to physical needs, he is by intuition a good psychiatrist and makes outstanding contributions to the emotional health of his small proteges.

Pediatricians who are adept at spotting emotional problems in children follow certain general principles. Not only is a thorough physical examination performed. A detailed history is taken if this has not been secured before and scrutiny is given to the child's personality and to possible defects of it. Following this exhaustive examination which is discussed briefly

below, it is possible to evaluate the child's total situation in order to reach conclusions about the nature and severity of the illness and what treatment is necessary.

PSYCHIATRIC HISTORY TAKING

This involves securing data concerning the patient's family, developmental period, school life, social adjustments, medical and surgical conditions and the present illness.

In respect to the patient's family, it is not sufficient to determine the age and state of health of the parents and siblings. The home environment has a tremendous bearing on the development of the child's personality. In the home the parents are the most important elements because the child depends on them for emotional security, the most basic need of his life. Undesirable attitudes on their part lead to insecurity in a child which arouses hostility and anxiety in a degree proportionate to the stimulus. Parental quarrels, including those concerning the management of the child, inconsistencies of all types, lack of attention to the child, over-protection, over-indulgence, threatening, bribing, lying, breaking promises, giving insufficient praise and encouragement, excessive criticism, lack of discipline and harsh discipline are some of the many pitfalls to be guarded against in the career of parenthood. Over-protection, with its roots in the guilt-feelings aroused by unconscious hostility toward the child, tends to keep the child excessively dependent on the parent, permits insufficient freedom for him to grow as an individual and may lead to fears inhibiting action. Over-indulgence may simply indicate an attempt of the parent to compensate for inadequate love and attention by offering an over-abundance of material "goods." Complete lack of discipline or restraint, with absolute freedom for the child to follow his own desires regardless of those of others, is poor preparation for adult life where one's attitudes and behavior must conform to those of the social group or one must suffer the consequences. All these unhealthy attitudes on the part of the parents lead to considerable disturbance in the parent-child relationship. Whenever such disturbance is discovered, an attempt should be made to correct it. If this can be done early enough it constitutes excellent prophylaxis. Later on when the child shows more definite signs of maladjustment, it is an important part of the treatment.

Of the two parents, the mother's influence on the child is far more significant than is the father's because most of the child's early experiences are in relation to her. She feeds him, weans him, changes his diapers, toilet-trains him, attends him when he cries and amuses him. In so doing, she lays the foundation for a later sense of security or lack of it. Frustrate him she must, by seeing to it that he gives up his infantile pleasures of

suckling, soiling, wetting, etc., but the frustration and subsequent hostility can and should be tempered by the giving of much love. The frustration is increased if the demands on the child are too early, too abrupt, too rapid or enforced by punitive measures, and if there is an absence of loving attention, encouragement and praise.

The position of the child in the family should be determined, as this has a bearing on his emotional life. For example, an older child may feel cheated and deprived of his parents' attentions and may feel the need to struggle to maintain his superiority over the younger siblings; a youngest child may be over-indulged by the parents with consequent perpetuation of his babyish ways. Every child needs careful preparation for the birth of a sibling. All of them respond at first to the younger child with jealousy. Unless excessive, this reaction disappears when they are given plentiful reassurance of parental affection and privileges corresponding to their developmental status. The physician can often alleviate the parents' unnecessary worries about the manifestations of the child's jealousy.

With the school age come new difficulties in adjustment but ordinarily these are not insurmountable. The physician should determine whether the child is making normal progress in his studies and whether he has desirable attitudes toward teachers and classmates. Retardation in school work, inattentiveness, over-submissiveness, aggressive and defiant behavior, non-participation in extra-curricular activities and poor relationships with classmates—all point to maladjustment of varying degrees of severity.

Investigation of the child's social adjustment involves finding out whether he makes friends easily, how many friends he has, how long his friendships last, whether he belongs to clubs, what he does with his spare time, what his religious training has been, how great is his interest in religion now, whether he has been given sexual information by the parents or shielded from it, what his sexual experiences have been, etc.

The medical history will indicate the present state of the child's physical health and whether he has had physical illnesses, accidents or operations which might bear some relationship to his emotional maladjustment. Some medical conditions, for example, an old encephalitis, may be the direct cause of the emotional disturbance. Others may be of importance only insofar as they have resulted in some increase of the child's anxiety about himself, or in an excessive amount of attention from the parents.

In securing a history of the present illness, it is sometimes quite a task to elicit from the parents complaints other than the presenting one, but these should never be neglected. Often parents will mention only one symptom—that which for some reason is more disturbing to them—even though others of equal or greater importance are present. For example,

the writer recently studied an eleven year old boy who was brought by his mother for the problem of night enuresis. On further questioning, the mother mentioned his extreme restlessness, marked suspiciousness, inability to make friends and voracious eating, all of which pointed to the fact that his maladjustment was considerably more severe than first indicated by the mother. It is important too, to determine how long a symptom has been present. Possibly if it is of short duration it can be traced to some unusual event in the environment which may right itself in time or can be corrected or attenuated by the parents with the help of the physician. For instance, it may have been precipitated by the birth of a sibling, illness of the mother, the mother going to work or the father going to war.

PHYSICAL EXAMINATION AND FINDINGS

A thorough physical examination should never be neglected. A positive physical finding can account for an emotional disturbance but not necessarily so. Many children react temporarily to physical illness with fearfulness, exaggerated dependence on the mother, whining, aggressive behavior, withdrawal, etc. However, unless an exhaustive examination very definitely establishes a direct causal relationship, it should not be expected that the correction of physical conditions will result in improvement of the emotional disturbance. Attendance to very minor physical ailments is not to be given at the price of unnecessary delay in psychiatric treatment. Some types of "physical" treatment for emotional problems may in themselves actually constitute severe emotional trauma to the child.

Two examples will be given of cases in which medical treatment did not bring about improvement in the child's emotional problems because these problems did not have a physical basis.

Bill, a nine year old boy, was seen by a physician because he masturbated "almost continuously" and was slightly under-developed for his age. He was given pituitary injections and thyroid medication but "at no time did the masturbation improve." Removal from a very traumatic home environment and commencement of treatment in a psychiatric residential school was followed shortly by cessation of excessive masturbation. In psychiatric interviews he brought out clearly that he had regarded the injections as a punishment for the masturbation.

Polly, an only child, aged eight, was referred to a psychiatrist (finally) because of finicky appetite, excitability, disturbed sleep and excessive dependence upon the mother. The father was a cripple and the mother had many hypochondriacal complaints. Polly had been seen regularly over several years' time at a medical clinic and because of her finicky

appetite she had been given thyroid medication. Several months later, although there was a questionable improvement in her appetite, she was even more excitable than before. It was at this point that she was seen by another physician who recognized the emotional nature of her problem and advised psychiatric consultation.

SCRUTINY OF THE CHILD'S PERSONALITY

The concept of normality and all possible deviations from it cannot be adequately discussed in the confines of a very brief paper. However, the writer's wish is to stress the fact that each new stage of the child's development—infancy, preschool, elementary school, and adolescence—brings with it fresh conflicts with resulting difficulties in adjustment. If this is kept in mind, evaluation of the total situation may sometimes lead to the conclusion that the child has not "a problem" but only emotional "growing pains," about which the parents are unnecessarily disturbed. In general, if a child is doing well in school, is not overly shy, has many friends and can meet new situations well, one is reasonably safe in thinking that any symptoms which he has are not a sign of profound maladjustment and can be corrected by talking with the child or by manipulation of environment or by a combination of methods. This less severely disturbed child can usually be treated successfully by a physician who has had training in child psychology, leaving only the more severe cases for referral to the psychiatrist.

The signs of abnormality are almost legion. Recently the writer was impressed by a letter received from a mother who, after enumerating a dozen severe problems her son has, concluded, "He is like any other child, only more so." It is true that the maladjusted child differs from the normal only in being "more so" or "less so" or "different." All signs of maladjustment are indications of insecurity and unhappiness in the child and never of "badness" as so many parents think. Occasionally the child expresses his unhappiness in words. More frequently he uses the language of behavior or bodily symptoms. Examples of these various types of expression are given in other papers in this bulletin.

SUMMARY

The importance of early recognition and appropriate treatment of emotional maladjustments in children is stressed. It is pointed out that the pediatrician can make and is making a valuable contribution to this. It is urged that children be given an exhaustive examination, including not only the usual thorough physical examination but also complete history taking from the parents and scrutiny of the child's personality.

THE PSYCHOLOGICAL TESTING OF CHILDREN: INTELLIGENCE AND EMOTIONAL ADJUSTMENT

By SIBYLLE K. ESCALONA and DAVID RAPAPORT

All those who are responsible for the care of children and infants whether it be in the capacity of psychiatrist, pediatrician, teacher, social worker or parent, are confronted with the necessity of assessing the developmental status and capacities, as well as the specific psychological characteristics of children. Psychological tests of intelligence comprise one of the available sets of tools which may be used profitably to obtain a systematic comparison between the level of mental functioning of a particular child and the majority of children of his age-group. However, recent developments in psychological testing go beyond the assessment of intelligence. Psychological tests are becoming tools of understanding personality structure, of assessing types of adjustment and maladjustment, and thus are beginning to serve also as diagnostic and prognostic instruments.

As is the case with any other scientific instrument, the value of psychological tests for infants and children depends upon the manner in which they are used. In the past, psychological testing of children has too often been limited to the calculation of an intelligence quotient. On the basis of such a result important decisions have been made on the tacit assumption that an intellectual deficiency or superiority is a constant and unchanging characteristic of the person, and a valid basis for future planning. In the light of recent findings in regard to the variability of the intelligence quotient with varying environmental conditions, such over-evaluation of intelligence status must be considered a misuse of psychological testing procedures. Intelligence test results and, for that matter, any test results should be used only in conjunction with clinical examination results, because it is in that context that their real meaning and value can be understood and exploited. On the other hand, psychological tests are frequently not used in situations where they might make a real contribution to the understanding of a case. The underestimation of, or lack of information about, this possible contribution is just as widespread as overuse and misuse of tests.

The pediatrician and the child psychiatrist encounter a series of situations in which psychological testing of the child in question may be of great help and even indispensable. In the following, the kind of situations in which psychological tests can make a contribution will be briefly described and the nature of such contributions summarized.

A. Disturbances of Intelligence. A child may come to the attention of the psychiatrist because of poor school achievements, or the pediatrician

may note poor school achievement in a child under his care. This poor school achievement may be due to any of a great number of factors:

1. The child may be ailing and consequently be absent so often that this itself may explain his poor achievement. In such cases the standard educational achievement tests [e.g., Stanford Achievement Test[4]] will yield poor scores at the same time as the intelligence tests will indicate adequate intelligence and efficiency.

2. The child's physical complaints and his frequent absences from school may both be expressions of a psychological maladjustment. This maladjustment may also be the basis for an even poorer educational achievement than is warranted by the absences. In such cases the intelligence test [e.g. Stanford-Binet[8], Minnesota Preschool[5], Wechsler-Bellevue[9], Cornell-Coxe[2]] may show either a generally poor efficiency or uneven achievement on different parts of the test, reflecting uneven development of the different functions underlying "intelligence." This in turn may indicate the necessity for personality testing [e.g., the Rorschach Test[7]] which will reflect the nature of the maladjustment.

3. A child may show poor achievement due to special disabilities or disturbances which lie in the sphere of the acoustic or visual sensory functions. These disabilities may be established by means of audiometric and optometric tests.

4. A child may also do poorly because of insufficient stimulation in the home or at school. In such cases the personality tests will indicate good endowment and no maladjustment while the achievement and intelligence tests will still be poor. Verbal intelligence especially (vocabulary, verbal concepts, etc.) will likely remain under-developed in such cases.

5. The child may, however, do poorly due to a general mental retardation, which may be either congenital or the expression of an emotional difficulty; or his low achievement may be the result of a specific retardation (reading, spelling, arithmetic difficulty) which again may be organic—in rare cases—or, more frequently, may have an emotional origin. In cases of congenital mental deficiency the intelligence and achievement tests are likely to show uniformly retarded development of the various functions involved in "intelligence," and the personality tests will also show patterns characteristic for mental deficiency. However, where the deficiency is a "pseudo-debility" of emotional origin, the personality tests will not show such patterns and the intelligence tests will show great unevennesses in the efficiency of various functions. Where the intelligence defect is due to acquired organic damage, the personality tests are likely to show a feeble-minded pattern, and in addition may reflect the presence of organic damage. Sometimes the damage may be covered over by the defective pattern.

However, the intelligence tests are likely to show very great unevennesses of functioning. Special reading, spelling and writing tests are used to analyze the nature of special disabilities.

6. Finally a child may do poorly due to impaired efficiency on the basis of the kinds of maladjustment which are usually called "behavior disorders," a neurosis, or even a psychosis of childhood. These will be dealt with below, because in these the intellectual retardation is really a side issue.

B. Disturbances of Emotional Adjustment. A child may come to the attention of the child psychiatrist because of an apparently "minor" behavior difficulty or such may be noticed by the pediatrician in a child in his care. Such "minor" behavior difficulties may be untidiness of all degrees, thumb-sucking, nail-biting, fearfulness, shyness, quarrelsomeness, "wildness," masturbation, poor eating, poor sleeping, etc. In all these cases one may deal with transient developmental symptoms, with essential manifestations of a neurosis, or even with a relatively innocuous-appearing symptom of a generalized and malignant maladjustment—possibly of psychotic degree. In such cases the personality tests and tests which obtain samples of the child's phantasies (such as play-techniques or the Thematic Apperception Test[6]) are important tools for assessing the seriousness of these symptoms. In such cases the tests are an especially important adjunct of diagnosis, although, in contrast to their frequent use in cases of intellectual retardation, they are used all too little. Yet, for these cases, where the essential disturbance is obscure and the symptom apparently innocuous or at the most very annoying, *all* available tools should be marshalled to assess the degree of seriousness of the underlying maladjustment. Only such a procedure will provide a sound basis for a decision in regard to those difficulties requiring immediate attention and those which do not need to be treated and can be left to development to take care of. Frequently the intelligence tests can be of help here because the severity of the maladjustment is often proportional to its encroachment on the efficiency of intelligence.

The child may come to the attention of the child psychiatrist, or may become conspicuous to the pediatrician among his patients, because of an act of "delinquency" such as stealing, lying, fire-setting, or sexual delinquency. In such cases again it may be difficult to determine whether the behavior is due to mental deficiency, to environmental conditions that may foster it, or whether the delinquent activity is an expression of a developmental difficulty referring especially to development of "conscience," of a neurosis, a psychosis or a character-formation which presages the child's growing up to become a full-fledged psychopath. In these cases mainly the personality and "phantasy" tests are helpful in establishing whether

the delinquency is *symptomatic* of neurotic or psychotic maladjustment or an expression of an inadequate *development* of conscience. In the latter case manipulative skills are frequently superior to verbal skills and thereby the intelligence tests become diagnostically helpful.

Even when the child comes to the attention of the pediatrician through a generally poor bodily development, or with specific somatic conditions, such as allergies, hives, chronic stomach upsets, chronic bowel difficulties (diarrhea, constipation, etc.), such conditions, and especially their chronicity, should raise the question: is a maladjustment in the psychological sense present? In these cases the same considerations and testing procedures are in place as were described for symptomatic maladjustment.

Finally even where a child comes to the attention of the psychiatrist, or becomes conspicuous to the pediatrician, with clearly neurotic symptoms: speech defects, temper tantrums, obsessions, compulsions, withdrawal, "delusions," queer mannerisms—the question of differential diagnosis may still be present. In these cases the tests are useful to differentiate psychotic from non-psychotic conditions. The former goes with profound unevenness of intelligence development, disorganized phantasying and "typical" personality patterns.

Thus in all these cases it is worthwhile to obtain psychological tests of one or the other kind because they may indicate whether the advice and care of the pediatrician is sufficient to cope with the problem or whether it is a case where psychiatric attention is advisable or mandatory. The tests may indicate whether a problem, which in its presenting form has no relationship to intelligence development and achievements, is one which will eventually invade those fields as well. The tests may indicate whether the problem is of such scope that it can be solved within the existing environment of the child or whether it is such that residential-psychiatric placement of the child is required.

C. The Testing of Infants. Psychological testing can often be of practical significance in work with infants and very young children. This is true where infants fail to develop at the expected rate, or where infants cause concern because of eating or sleeping irregularities that do not respond to the usual pediatric measures. Wherever infants are deprived of the close maternal solicitude which only their own mothers and a stable family background can provide, infant testing becomes especially important. It provides one means of checking on the success of the foster-home and adoptive placement, in addition to the customary check-ups in regard to physical development.

With infants and small children the Gesell[3] and Cattell[1] scales are most frequently used. Combined administration of both these develop-

mental scales has been found useful. The Gesell schedule gives an estimate of the child's motor development, his development in the sphere of adaptive behavior, his language development and his development in the area of personal-social behavior. The use of this scale makes it possible, therefore, to specify any retardation or acceleration in development with reference to the aspect of growth where it occurs. Such information when combined with rather complete histories which include not only medical facts but also the type of training the child has received, the amount and kind of stimulation to which he has been exposed and other relevant items, may give valuable clues as to the nature of the retardation. Thus, where one finds a retardation primarily in the sphere of personal-social development, with normal growth in the other areas, there exists sufficient warrant to suggest changes in the child's environment which will provide for a greater amount of stimulation in this area. It may be recommended, for example, that the child receive more individual attention and more affection than has been the case before the test revealed this deficiency. This aspect of testing is especially applicable to children who are reared in foster-homes or who are to be adopted, inasmuch as homes may be selected in part on the basis of the child's needs, as indicated by psychological tests.

Psychological testing of infants and young children is as yet only a partially developed field, and there is need for more systematic research work in this area. Although behavior norms have been established for certain standardized test situations, little is known about the behavior repertoire of infants in response to the ordinary events of home life which call for adaptations different from those elicited in laboratory situations. Experimental studies and time-sample observations of infant behavior are essential in order that test results may be evaluated more meaningfully against the background of knowledge established through such studies. Psychological tests will not reach an optimal clinical usefulness until more is known about variations in infant behavior due to variations in the environment and until the genesis of those functions which are tapped by the psychological examinations is more fully understood.

In summary it may be said that psychological testing of children meets a variety of needs arising in medical, psychiatric, or educational practice. By means of an analysis of the different degrees of retardation and acceleration of development, and of the specific nature of atypical forms of mental functioning, testing may help to differentiate between the manifestations of congenital mental deficiency, of specific disabilities, and of various types of maladjustment. This type of psychological testing service reaches its maximum usefulness only when it is used in conjunction with clinical investigation procedures.

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THE ROLE OF THE SOCIAL CASE WORKER IN THE BOARDING HOME PLAN OF THE SOUTHARD SCHOOL

By DOROTHY G. WRIGHT

The boarding home plan of the Southard School has been in operation for almost three years and is now an accepted and proved technique in the school's treatment of neurotic children. Parents are informed of the plan upon admission of their child. The children anticipate going from the school to a boarding home as an indication of their progress. Ten of the twenty-two children in the school live in boarding homes.

The arrangements with each home are based on the child's individual needs. In general, however, the child is in the boarding home from 5:00 in the afternoon until 8:30 the following morning with the exception of Saturday and Sunday when he is with the boarding home family all day. If the boarding home parents wish to go out of town or make other plans in which The Southard School child cannot be included, immediate arrangements are made for the child to come back to the school for whatever period the family will be absent. All boarding homes are paid the same fee for board, room and child care. Such items as laundry, cleaning, allowances, recreation with the family, and clothing are separate charges which are listed by the boarding home and this expense account is turned in each month for reimbursement. All medical needs of the child in the home are handled by the Southard School physicians.

The use of the boarding homes for children under psychotherapy has many unique features which are not found in the usual children's agency boarding home plan. Here are a few of them:

1. The children placed by the Southard School have more problems and are usually more disturbing to the boarding home than the average child placed by a children's agency. The initial stage of the child's adjustment in the home is often relatively unmarked by abnormal behavior. During this period the boarding home parents tend to accept the child as normal and at times resent his being at the school. Then when bedwetting, soiling, stealing, tantrums and other emotional problems appear, the boarding home parents face a real problem of incorporating a sick child into their home. If they have children of their own this adjustment presents many complications. If more consideration is given to the Southard School child, their own youngsters are jealous and feel rejected. Even the matter of privileges and application of standards in the home has to be altered to include the child who is emotionally disturbed. It is a real challenge at times to make this neurotic child an integral part of the family and still maintain the family unit. In one of our boarding

homes this has never been accomplished and the Southard School child remains merely a "star boarder." There are other very fine features of this home which compensate for this factor and the child happens to be one who does not need deep personal attachments, so we have not made a change here. With most of our children such a relationship would defeat the purpose of placement. Here are a few examples of the type of children our boarding homes agree to take:

Case A—A thirteen year old boy, of normal intelligence but extremely retarded in school, who engages in a great deal of rude, rough behavior. He needs much affection, firm handling, and a great deal of encouragement because he believes he cannot learn and cannot do other things normal boys do.

Case B—A very mature fourteen year old girl who has been failing consistently in school despite a high I.Q. She has run away, has temper tantrums and always manages to get her own way.

Case C—An attractive twelve year old boy who has a history of stealing and lying. He has no conception of getting along with people. He thinks he has to fight for everything or pay somebody off for any consideration received. He is also retarded in his school work and is a very intelligent youngster.

2. These children come from homes where the physical surroundings have been most adequate and in some cases, luxurious. In an agency the caseworker often finds it difficult to refrain from "overplacing" a child who has come from a very poor home. Here at the Southard School, we have to guard against "under-placement." Sometimes an "under-placement" may be desirable for a child who has had "everything" but his own parents may have difficulty in appreciating the values for which such a home is chosen. It is necessary in such instances to explain exactly the kind of environment the school is trying to secure for the child. There is also another problem here from the point of view of the boarding home parents. If they are rearing their own family on a very limited budget, they may resent the apparent wealth of a Southard School child who has expensive clothing, toys and gifts. So it is important to locate for these children homes of higher economic level in the community. Most of these are found among professional groups and business executives. In fact, our present families include the following types of persons: a junior high school principal, a teacher of agriculture in a rural high school, a railroad executive, a state insurance agent, a legislative research specialist, a college professor, an executive of a service corporation company, a boy scout executive and a real estate salesman.

3. Southard School homes must be especially selected to meet specific needs of the child. The psychotherapist gives the caseworker definite

requirements for a boarding home. These requirements differ with each child placed. One child may need a home where there are no children, another may require the companionship of children who are older or younger than the patient. A protective mother may be needed for one child and a very lenient one for another child. Sometimes it is very important to find a home in which the father is the dominant figure; in another case there need be no father figure in the home. Because of these specific requirements, voluntary applications for children do not usually meet the definite needs outlined. It is necessary then for the psychiatric caseworker to go out into the community, locate the type of home requested for a particular child and then persuade the family to become interested in the boarding home plan. This is contrary to most agency procedures where value has been placed on the voluntary application of a home for a child.

4. The procedure of placement at the Southard School is more complicated and involved than that set up by most children's agencies. A complete social investigation is made of the home, and references are checked. At times the social history of the family is difficult to obtain because the persons in the home are well-to-do, respected citizens of the community who resent having to give personal information to the caseworker. When the history is completed the child's therapist visits the home with the caseworker. If the therapist does not approve of the home for the child being considered, another home must be sought. The family is given an adequate explanation as to why the particular child was not placed in this home and it is put on the waiting list for another child.

If the therapist likes the home, however, and believes it will meet the needs of his child, the family is encouraged to invite the child to the home for an evening meal. The child is told that he need not go to this home unless he wishes to do so, and that the boarding home family must want him or he cannot move into their home. The boarding home family also understands that it need not accept the child unless the members of the family feel that he can be included in the family life. Then if the child and the boarding home family are congenial, the placement is made. However, even this is done on a temporary basis. If at any time the boarding home parents do not wish to keep the child they are free to give the school two weeks' notice. The school may also remove the child from the home on two weeks' notice when the therapist feels that the situation requires it.

5. The information which the Southard School has about the boarding home children is much more detailed than that in most social histories and is more confidential in nature. The social worker has to give enough of

this information to the boarding home parents to interest them in the child and to enable them to understand him, but at the same time she must make the family thoroughly aware of the extremely confidential nature of their knowledge of the child. She prepares them for the questions which their friends and neighbors will ask, and explains what can be said about the child's presence in their home. The selection of the information given to the boarding home and the formulation of the attitudes which the family should maintain are worked out by the caseworker and the therapist before the placement is made.

6. The social worker makes it very clear to the boarding home parents that the children cannot be adopted. The need of these children for realistic home ties must be recognized and fulfilled, however, particularly in cases where the home relationship is an essential element in the treatment of the child. At times the boarding home mother needs considerable support with the conflict she may have between her desire to give the child the love and affection she feels for him and her knowledge that he will undoubtedly return to his own home sometime in the future. Boarding home mothers who care for very maladjusted children often become more emotionally involved with the child than do mothers who have children who require less care. Naturally children who are orphans or who have a deceased mother tend to build up a more permanent relationship with the boarding home than those whose parents are living and visiting and writing the child at the school.

7. The relationship between the actual parents and the boarding home is handled by the psychiatric caseworker through the school administration. In general, all contacts between the two groups of parents are discouraged. The boarding home is often felt as a definite threat by the child's parents. At times it is necessary for the caseworker or child psychiatrist to have several interviews with the parents to help them overcome their resistance to placement.

Contacts between the two families tend to complicate the situation not only for the parents but also for the child. In most cases the boarding home should consistently be identified with the school in the child's mind and should not be confused with his own family relationships. Parents who visit the boarding homes find it difficult to refrain from giving instructions or from referring to problems which they have encountered with the child. If the child becomes aware of this, he tends to identify the boarding home with his own home. This situation is particularly detrimental when the child has rejected his own parents or is resistant to their control.

Parents can visit the boarding home of their own child, however, if they wish to. Some persons seem to feel more secure about the care of

their boy or girl when they have seen the home and met the boarding home family. In such a case, arrangements are made for a "social" call at the home, and if possible the parents are accompanied by the caseworker. The boarding home parents are requested to refer all questions concerning the child's development to the school.

8. The Southard School boarding homes are subject to much more intensive supervision than is given by most social agencies. This supervision entails a weekly interview with the caseworker when a "running report" of the child's behavior and reactions during the past week is given by the boarding home parents (usually the mother). For each child the therapist may request special observation and details. With one child it may be important to notice any repetitive actions, with another to list all phantasies told to the members of the family. If the child is a bedwetter the parents are asked to report carefully the happenings of the family before bedtime. Any acts of lying, stealing, sexual behavior, etc. must be noted and reported to the caseworker, with their attending circumstances, as well as items of satisfactory behavior.

Naturally the boarding home parents need to be aware of the nature of psychotherapy and sympathetic toward the efforts of the therapist, in order to gather and report the information which will be of value in promoting the treatment of the child. The fact that the child has a therapist to whom he tells all of the happenings of the home acts as a threat to some boarding home parents. They fear the criticism of the therapist and unless they understand thoroughly the relationship of the child to the therapist, they may refrain from using their own judgment in the matter of discipline. The caseworker must constantly assure the foster parents that they have a Southard School child because they are good parents. We expect them to use their best judgment and give the child the same sort of privileges and controls that they would give their own child. They are reminded that the school is not paying "room and board," but is paying them to include this child in their family. If they give him all of the advantages and none of the discipline they are not being fair to the child. On the other hand, if their judgment has been poor and a particular method seems to be detrimental to the treatment of the child, the therapist will make other suggestions for similar situations in the future.

The information received from the boarding home is relayed to the child's therapist in weekly conferences. Then the caseworker takes back to the boarding home any suggestions which the therapist may have for the home situation. In general the boarding home parents cooperate with the school very well indeed. This is partly because of the initial care used in selecting the homes, partly because of the high level of intelligence and insight of the boarding home parents, and partly because of good rapport with the School and a belief in the value of the work it is doing.

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